immersiv HEALTH

OCREVUS® ORDER FORM

FAX TO: 855.694.4656

PATIENT INFORMATION

PATIENT NAME: _____ **PHONE:** _____

DATE OF BIRTH: _____ **SEX:** ☐ M ☐ F **HEIGHT:** _____ **WEIGHT:** _____ ☐ LBS ☐ KG

ALLERGIES: _____ **PREFERRED CLINIC:** _____

REFERRAL STATUS: ☐ NEW REFERRAL ☐ ORDER CHANGE ☐ ORDER RENEWAL

DIAGNOSIS & CLINICAL DOCUMENTATION

☐ G35 Primary Progressive Multiple Sclerosis

☐ G35 Relapsing Remitting Multiple Sclerosis

☐ ICD-10 CODE: _____ DESCRIPTION: _____

REQUIRED DOCUMENTATION

☐ Insurance Information

☐ List of Medications

☐ Tried & Failed Therapies

☐ Most Recent History & Physical

☐ Negative Hepatitis B

☐ Quantitative Serum IG screening

MEDICATION ORDER

☐ **LOADING:** Ocrevus® (ocrelizumab) 300mg IV in 250ml NS over 2.5 hours at week 0 and 2

☐ **MAINTENANCE:** Ocrevus® (ocrelizumab) 600mg IV in 500ml NS over 2 hours or as tolerated every 6 months

* Maintenance dosing scheduled 6 MONTHS from initial Week 0 dosing

☑ REFILL X 12 MONTHS UNLESS OTHERWISE NOTED HERE:

_____

PRE-MEDICATIONS

REQUIRED

☑ Acetaminophen: 500 mg	☑ PO	☐ IV
☑ Methylprednisolone: 125 mg	☐ PO	☑ IV
☑ Diphenhydramine: 25 mg	☐ PO	☑ IV

OTHER: _____ ☐ PO ☐ IV

Patient to be observed for 60 minutes following each administration.
In the event of an adverse reaction occurring in the infusion clinic, utilize the Immersiv Health adverse reaction protocol.

PRESCRIBER INFORMATION

PROVIDER NAME: _____ **NPI #:** _____

EMAIL: _____ **PHONE:** _____ **FAX:** _____

ADDRESS (INCLUDE CITY, STATE, ZIP): _____

SUPERVISING PHYSICIAN: (IF APPLICABLE) _____ **CONTACT NAME:** _____

SIGNATURE: (NO STAMPS) _____ _____ **DATE:** _____

SUBSTITUTION PERMITTED DISPENSE AS WRITTEN